DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **01-005**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

FILE COPY

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ (1,000,000)
b. FFY 2002 $ (1,000,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A

Pages 1 through 34

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A

Pages 1 through 33

10. SUBJECT OF AMENDMENT:

Payment Rates and Methodologies for Inpatient Hospital Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
DENNIS BRADDOCK

14. TITLE:
Secretary

15. DATE SUBMITTED: 3/30/01

16. RETURN TO:
Department of Social and Health Services
Medical Assistance Administration
623 8th St SE MS: 45500
Olympia, WA 98504-5500

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JAN 29 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 1 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Teresa L. Tremblee

22. TITLE: DEPUTY REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID

23. REMARKS:

3/30 DATE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

The State has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

A. INTRODUCTION

The State of Washington's Department of Social and Health Services (DSHS) implemented a Diagnosis Related Groups (DRG) based reimbursement system for payment of inpatient hospital services to Medicaid clients in the mid 1980's. This system as revised through this amendment, is used to reimburse for admissions on or after January 1, 2001. Revisions to this system are made as necessary through amendments to the State plan.

The standards used to determine payment rates take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. The system includes payment methods to hospitals for sub-acute care, such as skilled nursing and intermediate care, and payment methods for lower levels of acute care such as Long Term Acute Care (LTAC), and Level B Inpatient Acute Physical Medicine and Rehabilitation (PM&R) care. The rates for these services are lower than those for standard inpatient acute care. This includes Level B PM&R care provided by skilled nursing facilities acting as Level B PM&R centers.

The reimbursement system employs three major methods to determine hospital payment rates: DRG cost-based rates; DRG contract rates; and rates based on hospitals' ratio of costs-to-charges (RCC). The DRG and RCC payment methods are augmented by trauma care payment methods at state-approved trauma centers. The trauma care enhancement is an increased percentage provided to the base Medicaid rate. The amount of trauma care enhancement varies contingent upon State legislative funding for the Department of Health's Trauma Program.

A fixed per diem payment method is used in conjunction with the Acute PM&R and LTAC programs.

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Contract hospitals participating in the federally waivered Medicaid Selective Contracting Program are paid for services based on their contract bid price and/or an RCC method. Hospitals not located in contract areas and hospitals exempt from selective contracting are reimbursed on a cost-based DRG rate and/or an RCC method, or fixed per diem method.

Non-contract hospitals in selective contracting program areas provide emergency (including maternity) services, and other DRG exempt services such as AIDS related care. These hospitals are reimbursed on a cost-based DRG rate and/or under the RCC method.

Certain hospitals and services are exempt from the DRG payment methods, and are reimbursed under the RCC or fixed per diem payment method.

The following plan specifies the methods and standards used to set these payment rates, including: definitions; general reimbursement policies; methods for establishing cost-based DRG rates; methods for establishing RCC payment rates; upper payment limits; and administrative policies on provider appeal procedures, uniform cost reporting requirements, audit requirements, public notification requirements.

B. DEFINITIONS

The terms used in this plan are intended to have their usual meanings unless specifically defined in this section or otherwise in the plan.

1. Accommodation and Ancillary Costs

Accommodation costs: the expense of providing such services as regular room, special care room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

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Ancillary costs: the expense of providing such services as laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including anesthesia and postoperative recovery rooms). Ancillary services may also include other special items and services.

2. Case-Mix Index (CMI)

Case-mix index means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using DRG weights as a measure of relative cost.

3. DSHS

DSHS means the Department of Social and Health Services. DSHS is the State of Washington's state Medicaid agency.

4. Diagnosis Related Groups (DRGs)

DRG means the patient classification system originally developed for the federal Medicare program which classifies patients into groups based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. The DRGs categorize patients into clinically coherent and homogenous groups with respect to resource use. The Washington State Medicaid program currently uses The All Patient Grouper and has established relative weights for 400 valid DRGs for its DRG payment system. There are an additional 168 DRGs that are not used and another 241 DRGs with no weights assigned. Of the 241 DRGs with no weights, two are used in identifying ungroupable claims under DRG 469 and 470. The remainder of the 241 DRGs are exempt from the DRG payment method. The All Patient Grouper, Version 14.1 has a total of 809 DRGs.

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5. Emergency Services

Emergency services means services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are treated as emergency services.

6. HCFA

HCFA means the Department of Health and Human Services former Health Care Financing Administration (HCFA), renamed the Center for Medicare and Medicaid Services (CMS) in June 2001. CMS, formerly named HCFA, is the federal agency responsible for administering the Medicaid program.

7. Hospital

Hospital means a treatment facility which is licensed as an acute care hospital in accordance with applicable State laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

8. Inpatient Services

Inpatient services means all services provided directly or indirectly by the hospital subsequent to admission and prior to discharge of an inpatient, and includes, but is not limited to, the following services: bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and, services provided by the hospital within 24 hours of the client's admission as an inpatient.

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9. Long Term Acute Care

Long Term Acute Care (LTAC) means prior authorized inpatient services provided directly or indirectly by a State designated Long Term Acute Care hospital. LTAC services are authorized, subsequent to patient admission, but after the treatment costs in a DRG paid case have exceeded high-cost outlier status. At the point that determination is made the mode of care and reimbursement, if authorized by DSHS may switch to LTAC under a fixed per diem rate. This is not sub-acute care, rather this is intensive acute inpatient care provided to patients that would otherwise remain in intensive care or a similar level of care in or out of a hospital's intensive care unit.

The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient and is updated annually through an inflation adjustment.

The LTAC services include, but are not limited, to: bed and board; services related to medical, nursing, surgical, and dietary needs; IV infusion therapy, prescription and nonprescription drugs, and/or pharmaceutical services and total parenteral nutrition (TPN) therapy, up to two hundred dollars per day in allowed charges; and medical social services furnished by the hospital.

10. MI/GAU

MI/GAU, as used in Paragraph F.2 and F.3 below, means the DSHS Limited Casualty Program-Medically Indigent (MI) or General Assistance Unemployable (GAU) services.

11. RCC

RCC means a hospital costs-to-charges ratio calculated using annual HCFA 2552 Medicare Cost Report data provided by the hospital. The RCC, not to exceed 100 percent, is calculated by dividing adjusted operating expense by adjusted patient revenues. The basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed charges for medically necessary services.

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12. Operating, Medical Education and Capital Costs

Costs are the Medicare-approved costs as reported on the HCFA 2552 and are divided into three components:

Operating costs include all expenses except capital and medical education incurred in providing accommodation and ancillary services; and,

Medical education costs are the expenses of a formally organized graduate medical education program; and,

Capital-related costs include: net adjusted depreciation expenses, lease and rentals for the use of depreciable assets, the costs for betterment and improvements, cost of minor equipment, insurance expenses on depreciable assets, interest expense and capital-related costs of related organizations that provide services to the hospital. Capital costs due solely to changes in ownership of the provider's capital assets on or after July 18, 1984, are deleted from the capital component.

13. Uninsured Indigent Patient

Means an individual who receives hospital inpatient and/or outpatient services and the cost of delivered services is not met because he/she has no or insufficient health insurance or other resources to cover the cost. The cost of services for uninsured indigent patients is identified through the hospital's charity and bad debt reporting system. Charity care and bad debt, is defined by the Department of Health through its hospital cost reporting regulations WAC 246-453-010, (4) "INDIGENT PERSONS" (Supplement 1 to Attachment 4.19-A, Part I, Pages 1 through 10) and RCW 70.170 "HEALTH DATA AND CHARITY CARE" (Supplement 2 to Attachment 4.19-A, Part I, Pages 1 through 11), means those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200 percent of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payor; (5) "Charity care" means appropriate hospital-based medical services provided to indigent persons, as defined in this section.